Notes on visit to Mulanje and Nsanje

April 2016 David Melville & Jessica Mok

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Travel instructions driving from Blantyre to Kara O'mula Country Lodge, Mulanje (+265 1466 515).

You will see the mountain as you drive from Blantyre towards Mulanje. About 5 miles before Mulanje you come to a junction with no sign posts. Turn left towards Mulanje. A few miles down the road you will see a sign on the right to the Mission Hospital. You will cross a bridge and pass some shops (Chitakale) with a total garage. After the shops you cross a further bridge and then drive along an open road for about half a miles. As the road starts climbing you will pass a Puma garage followed by a stop sign. Immediately after this sign there is a turning to the left up the mountain to Kara O'mula ,which is then signposted as you progress up the hill. If you reach the district hospital you have gone too far and should turn back.

MULANJE MISSION HOSPITAL:

Monday 13/4/2016.

Arrived from Hotel at mission hospital in pm and became involved in treating hand sepsis in deep palmer space after emailing pictures to hand surgeon Drew Fleming in UK. Smaller case was drainage of foot sepsis associated with gouty tophus. Neither patient was properly anaesthetised.

Tuesday 14/04/2016

List arranged badly at mission hospital so only one elective case of 5-year old child with inguinal hernia which was treated by Dr Mok assisted by Mr Melville and paediatric medical officer. David Melville gave a talk at the morning meeting on preoperative assessment of elective surgical patients. Ward round in afternoon including hand patient – already much better.

Wednesday a.m.

Attended mission hospital morning meeting and then did ward round of patients. One severely ill girl with meningitis and elderly man with jaundice and anaemia.

Thursday a.m.

Jessica Mok gave talk on post operative care at the morning meeting. After this we drained an abscess in a 1 year old's neck. We were scheduled to operate on a hernia patient but his hernia was actually a mass of inguinal nodes. A lady scheduled for hysterectomy had a systolic of 240mm Hg and so was postponed.

Friday a.m.

Went to Mulanje District Hospital and delivered equipment from UK. David Melville presented at the hospital morning meeting. We then made arrangements for David Hunter's visit in 2 weeks time. We then performed a ward round with a medical officer of ward patients and made a video of a hernia patient. We attended a further drainage of a neck abscess in a child and saw a lady with abdominal pain who was pregnant.

MULANJE MOUNTAIN:

Over the weekend, we climbed Mulanje mountain with medical officer Ben Jacka where we shared a hut with Dr Douglas Poustels, a paediatric neurologist from Michigan University and an expert on cerebral malaria. He has been leading the research programme, which supplied the mri scanner to Queens Hospital Blantyre. He explained that they had chosen a low power scanner so that if the power failed the scanner would not have been wrecked.

NSANJE District Hospital.

Arrived lunchtime from Mulanje via Blantyre. Saw patients who had been chosen for operating list tomorrow including inguinal hernias, incisional hernias, prostate patients with indwelling catheters, a patient with a fistula in ano, a child with an inguinal hernia and a patient with severe bleeding following a catheterisation. Declined to perform prostatectomies and arranged list of hernias for tomorrow's surgery.

Met medical officers:

Pilirani Budala (piliranibudala@gmail.com), Francis Masanza, Gray Malata and Madalitso Gent.

The district health and medical officers were away attending training sessions at Blantyre focused on management rather than clinical skills. We were the only doctors in the hospital although we were not asked to examine problems outside our expertise.

Tuesday – attended morning meeting (7.30am) in NSANJE. We then checked our operative patients as an automatic blood pressure device had wrongly indicated they were severely hypertensive. Following this we went to theatre to start our operating list. The anaesthetist finally came at 9.30 wearing a purple wig and explaining that all the anaesthetic drugs except ketamine and lignocaine were out of date. We therefore decided to perform the two inguinal hernia repairs under local anaesthetic and cancelled the abdominal hernia repair. Jessica performed the first hernia repair on a man with a right inguinal hernia and absent left testicle. The left testicle had been lost in previous surgery when he was a child. It would appear that he had a large congenital hernia on the right which we treated by herniotomy and mesh repair. Pilirani Budala performed the next operation assisted by us and this was a repair of a large direct left inguinal hernia on a charming man. This was Budala's first mesh hernia repair and he was delighted.

Wednesday – attended grand round at Nsanje. We met a Brazilian doctor called Antonio who was working with MSF treating infectious diseases. The first patient had pre-eclampsia which enabled us to collect some data on obstetrics from the labour ward. The second patient was a 9 year old boy with acute bowel obstruction. We advised urgent surgery and offered to assist with his treatment but they preferred to transfer him to Blantyre. We then gave a talk on bowel obstruction and interpretation of abdominal xrays. We took with us a Canadian nurse – Terry Smith and with her we reviewed cases for the following day including a man with a melanoma over the sole of his foot. In the afternoon we carried out a clinic at the orphanage of about 15 patients – dysmenorrhoea was the commonest problem.

Thursday - Attended the morning meeting and then gave talks on pre-operative assessment. We then went to theatre where we operated on two inguinal hernias, a femoral hernia and a case of appendicitis. The first inguinal hernia contained an indirect sac, which was large and very adherent to the cord structures. The patient had to be catheterised half way through the procedure – a rather undignified procedure which failed. The bladder was then drained by puncture with an intravenous cannula passed through the anterior abdominal wall. The femoral hernia had been misdiagnosed and treated by an inguinal herniotomy about 6 months ago. The patient with appendicitis was aged 18 years and had a 2-day history of right sided abdominal pain. Since this was the first case of appendicitis for a year at Nsanje, we were scepticalof their diagnosis, but they were correct. We operated under spinal anaesthesia but as the patient had undiagnosed malrotation, the appendix was under the liver and we had to convert our initial McBurney incion to a lower midline incision. Returned in the dark to Iris at Bangula where we were entertained to dinner and given supplies for Nsanje Hospital (soap, bandages and linen).

Friday – Attended the morning meeting and gave further talks. Presented the gifts to theatres at Nsanje. We then undertook a ward round of the patients from Thursday. Thankfully they were all doing well. The young man with appendicitis was much better although he looked terrified – perhaps you should be asleep when people take your appendix out. Returned to Iris in Bangula and packed for departure to UK via Blantyre.

PS:

We found the Air Tel dongle lent to us at Iris with prepaid credit (5,000 kw for 2 gbytes), by far the best way to access the internet. Until we obtained this, email communication was very difficult.

The medical officers did not know how to tie knots nor did they understand surgical instruments. Perhaps each visiting surgeon should have string to demonstrate knot tying and a set of simple surgical instruments for hernia repair. Could we try to provide a simple hernia set to each hospital?

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